COMPREHENSIVE AND INTEGRATED CHRONIC DISEASE PREVENTION

Action Planning Handbook

for States and Communities

VERSION 1.0

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Partnership for Prevention's mission is to improve health by preventing illness and injury and by promoting health. Our aim is to heighten prevention as a priority in health-related policy and in the United States health care system as a whole.

The *Comprehensive and Integrated Chronic Disease Prevention: Action Planning Handbook for States and Communities* is an important project we have developed in pursuit of our mission. It is part of a larger project called *Chronic Disease Prevention: Action Planning for States and Communities*. The entire project is made possible with funding and support from the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.

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Washington (State) Department of Health
Public Health—Seattle & King County, WA

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INTRODUCTION

Comprehensive and Integrated Chronic Disease Prevention: Action Planning Handbook for States and Communities (Handbook) is part of a major Partnership for Prevention project designed to improve the effectiveness of statewide and community efforts to prevent chronic diseases.

The Handbook is intended to provide tools for health departments to use in assessing and identifying improvement strategies for their chronic disease prevention efforts. Specifically, it is aimed at helping you to find distinct opportunities for greater comprehensiveness and integration within a health department's existing chronic disease prevention efforts. It is based upon best practices found in the literature, the experience of technical assistance efforts, findings from case studies, and expert consultation. It focuses specifically on strategies to help state health departments, local health departments, and their partners work together in new and integrated ways.

Prior to developing the Handbook, three state and four metropolitan health departments were identified for case study to provide valuable experiences and lessons learned. The state health departments studied were those of North Carolina, Texas, and West Virginia, and the metropolitan health departments were Alameda County (CA), Boston (MA), City of Austin—Travis County (TX), and Contra Costa County (CA). Key factors identified for study, in terms of improving chronic disease prevention efforts, included partnerships, community engagement, policy advocacy, data management, planning, and integrated efforts. Examples from these sites are presented throughout the Handbook. (The case studies can be found at www.prevent.org/publications.)

To pilot test our findings and the utility of the Handbook tools, targeted technical assistance is being provided to five sites: Arizona Department of Health Services, Kansas Department of Health and Environment, Nevada Bureau of Public Health, Rhode Island Department of Health, and Washington State Department of Health in conjunction with Public Health—Seattle King County. This technical assistance is tailored to each site's particular needs to help them identify gaps in prevention efforts and to develop strategies for addressing priorities within a framework that fosters integration and promotes comprehensiveness.

Purpose of Handbook

The Handbook is for health departments that are ready to start the process of moving toward a more comprehensive and integrated approach to chronic disease prevention. The primary goal for the Handbook is to improve your overall impact on preventing chronic diseases while simultaneously improving the capacity and effectiveness of the individual programs that comprise a comprehensive effort. While the Handbook is focused on health departments, it could help lay the groundwork for engaging partners in a broader community effort.

The Handbook is not intended as a guide for comprehensive strategic planning or reconstitution of a health department. It is, instead, intended to illuminate potential and to help health departments, or several units within a health department, take the first steps toward creating a culture in which there is enhanced collaboration, coordination, and a shared desire to achieve greater effectiveness. It does so by guiding a self-selected planning group through a process of identifying and then implementing one or more "pilot" projects in comprehensiveness and integration. In this way, it encourages change through action and empiric learning.

Specifically, the Handbook will help health departments to:

a) Identify gaps in their chronic disease prevention efforts;

b) Develop comprehensive strategies to meet health priorities; and

c) Build more productive relationships across the organization and with partners.

How To Use This Handbook

The Handbook may be used as a stand-alone or as part of a broader technical assistance initiative. Individuals, groups within a categorical unit, several units, or an entire health department can come together to follow the steps toward defining and developing the pilot comprehensiveness and/or integration projects suggested in the pages that follow.

Worksheets are included to help bring to light possibilities for comprehensiveness and integration across chronic disease units and set you on the path to begin project planning. Above all, they offer a simple road map for exploring what a comprehensive and integrated approach could look like in your department.

SECTION I:
What Does Comprehensive and Integrated Chronic Disease Prevention Mean?

In the ideal vision of a chronic disease prevention program, comprehensiveness and integration go hand-in-hand. Yet they do have distinct implications. There are no absolute meanings for each term, nor is there one single health department model that would be considered the gold standard for both comprehensiveness and integration. Those interested in and working toward comprehensive and integrated approaches to chronic disease prevention are at the cutting edge of work in this area.

Comprehensiveness

For the purposes of this Handbook a comprehensive approach to chronic disease prevention:

- **Addresses the leading causes of death and disability (heart disease and stroke, diabetes, cancer, and arthritis);**
- **Addresses the major risk factors (physical inactivity, obesity, nutrition, socioeconomic indicators, and tobacco use); and**
- **Reaches the general population as well as targets high risk and priority populations in all the places in which members of the communities are found (schools, work sites, recreation areas, and religious and health care settings).**

Simply put, comprehensiveness asks,

- **Are you focusing on all the issues in your community to prevent chronic disease? For instance, are your cancer strategies covering all prevalent forms of cancer in your area, based on data?**
- **Are you reaching all primarily affected populations in your area?**
- **Are you working on eliminating the primary risk factors in your area?**

Integration

As a complement to comprehensiveness, the meaning of integration—sometimes referred to as synergy, coordination, or cross-cutting—is less about scope than about process.

Though laden with many meanings, integration does not mean a destruction of categorical areas of chronic disease prevention. Indeed, it offers ways for those categorical areas to have even greater focused impact.

North Carolina has one of the most comprehensive chronic disease prevention efforts of all states in the nation. Its core programs focus on both the most prevalent chronic diseases in the state (cancer, diabetes, heart disease/stroke) as well as critical risk factors such as physical inactivity, nutrition, and tobacco use.

Prevention activities in North Carolina are addressed not only to the general population but targeted to the populations with the greatest needs. The Diabetes program, for example, has created a series of special initiatives to reach targeted populations. The program is implementing a demonstration project in the African American community in and around Raleigh; the Commission of Indian Affairs is engaged in an interdenominational faith program working with Native Americans to reduce diabetes; another interdenominational initiative is being implemented through the Baptist Convention to train lay helpers and includes risk factors such as physical inactivity and nutrition. Finally, a Hispanic initiative includes obesity and is focused on primary prevention.

(See case study at http://www.prevent.org/publications.)

For the purposes of this Handbook, an integrated approach to chronic disease prevention:

- **Provides opportunities for programs to work together, promotes collective thinking and problem solving, and supports working together in new ways so that the impact of all programs is improved.**

Integration is not about adding work, but about doing work differently. As you will find by using the Handbook, taking integration measures, sometimes even modest ones, can address a major gap in comprehensiveness—sometimes with less work rather than more.

An example of an ideal opportunity for integration is,

> *A Cardiovascular Health Unit is working extensively with the African American community to educate, prevent, and treat hypertension. Yet, the Physical Activity and Nutrition Unit in the same health department has virtually no contacts within this population and has been at a loss to get their message across in that area, despite spending significant resources. Can the two units devise a cost-effective—even cost-saving—strategy to work together to jointly advance the effectiveness of their own programs?*

This Handbook is designed to illuminate scenarios such as the above and assess what a comprehensive and/or integrated approach to chronic disease prevention could look like in your health department.

Contra Costa Public Health Division is a prime example of an integration effort that grew into a formal restructuring to better align resources in support of integration. In one instance, the Division merged a number of prevention programs to create the Community Wellness and Prevention Program, which today develops and oversees a number of community-based public health initiatives. This structure helps to bring coherence to several programs that were previously pursuing similar aims but with little coordination or shared strategies.

Chief among the strategies for illuminating and developing opportunities for integration is the consistent and intensive use of a model they have developed called the "Spectrum of Prevention: A Model for Public Health Practice." The Spectrum focuses planning on seven areas—including mobilizing neighborhoods, changing organizational practices, and fostering coalitions—all geared to heightening the effectiveness of prevention efforts. (See Appendix B for Contra Costa Health Services, Spectrum of Prevention.)

(See case study at http://www.prevent.org/publications.)

SECTION II:
Making the Case

It is no secret that many public health professionals remain wary about the prospects and potential benefits of pursuing a more comprehensive and integrated approach to chronic disease prevention. Just the term "integration" may be perceived negatively and as a threat to program autonomy. Yet, the argument for finding better ways of working is clear. There continue to be growing health disparities in our nation: there is a tragic gap between where we are and where we can be with primary prevention.

While many in public health constantly strive to do more, to reach more people with more effective approaches, the suffering and mortality due to preventable chronic disease continues to affect our communities. At the same time, we know that funding is becoming harder to sustain. The pressure is on to make changes that can stretch our resources while creating greater impact. Comprehensiveness and integration, when done skillfully and with far-reaching staff commitment, offer a route to transform our level of effectiveness.

The Programmatic Challenge: *Why do it? It's more work and all I see are threats to my autonomy.*

The perceived threat to professional autonomy is a major barrier for many program directors and staff to embracing comprehensiveness and integration. But that common concern is a misapprehension of the underlying intentions of such strategies. As we know, there are scores of reasons to believe that embarking on a path toward greater comprehensiveness and integration will actually strengthen program effectiveness.

- **Increase individual units' impact on chronic disease rates and the overall health of the populations;**
- **Create awareness of shared aims across categorically funded programs and achieve common goals;**
- **Enhance efficiency in daily programmatic work;**
- **Facilitate more effective problem solving around persistent issues that inhibit reaching your goals;**
- **Improve learning from each other;**
- **Create better coordination of efforts to reach similar populations and/or to engage the same organizations; and**
- **Recruit more advocates for your cause.**

The Administrative Imperative: *Making Resources Go Farther, With Greater Impact*

As with categorical programs, there are administrative implications that point to the many virtues of seeking a more comprehensive and integrated approach to departmental work. While many of the benefits are the same—including the central benefit that it can reduce chronic disease rates in your community—there are very tangible operations benefits that can accrue from effecting such changes.

- **Improve efficiency and cost effectiveness with regard to the delivery of services and the quality of services;**
- **Address messages of encouragement or pressure from public health and political leaders;**
- **Reduce administrative costs and maximize program resources;**
- **Enhance coordination between various systems (e.g., medical systems, hospital systems, insurance systems, schools, work sites, businesses);**
- **Reduce duplication in addressing the same risk factors for different diseases and create greater efficiency in tackling multiple diseases;**
- **Develop more systematic identification of common problems and gaps and shared opportunities for addressing them;**
- **Increase sharing of data and best practices;**
- **Help more clearly define roles and responsibilities;**
- **Align policy-oriented units with clinically-oriented units; and**
- **Address credibility issues related to too many different messages coming out of different units.**

Often, it is the immediate pressures of political will or financial stringency that provide a health department the best field for true progress in becoming more comprehensive and integrated.

SECTION III:
Taking the First Steps

Convening Your Team

Making the decision to approach comprehensiveness and integration from within your department is an excellent starting point. But, of course, one person cannot do it alone. To lay the groundwork for completing the Handbook, you should assemble a Comprehensiveness and Integration (C&I) Team. Following the steps and worksheets that appear later in this Handbook, the C&I Team will go through the process of defining the scope of your initial C&I effort—one or more pilot projects aimed at enhancing your comprehensiveness or integration.

The Handbook is useful for any self-selected group within a public health department that wants to explore the possibilities of integration and comprehensiveness. Your C&I Team does not have to include every categorical unit in your department; it does not have to go beyond two or three.

To form a C&I Team, it is important to consider what individuals—representing specific units of chronic disease prevention—will be committed to the same operational or programmatic goals. Depending on the number of chronic disease staff in your health department, this initial C&I Team may eventually be expanded to implement the selected pilot project, or it may simply proceed into project implementation without adding any new members.

Within your team framework, it is important to have a discussion about who, exactly, should be at the table:

- **What role does the individual play within his/her unit?**
- **What is his/her reach?**
- **What are his/her particular interests in taking part in the planning?**
- **What are his/her goals?**
- **Have you all agreed on outcomes?**

The Texas Department of Health offers a useful example of a C&I Team in action. Its successful Nutrition, Physical Activity, and Obesity Work Group represents the Department's first major effort to implement integration. The work group seeks to integrate chronic disease prevention resources across traditional categorical and programmatic lines, bringing together staff members working on all of the state's disease-specific programs to focus on a single cross-cutting risk factor: obesity.

Today, all efforts and activities relating to obesity at the Texas Department of Health are organized through the Nutrition, Physical Activity, and Obesity Work Group to ensure efficiency, identify programmatic gaps, and eliminate areas of duplication. A core goal is to standardize messages relating to obesity throughout the Department to maximize effectiveness. While to date the work group has included only staff members, plans are underway to add partnering organizations to the mix in the near future, bringing its work to a new level of integration.

(See case study at http://www.prevent.org/publications.)

Above all, your C&I Team must include only those individuals who are truly committed to a genuine change process.

Early in the process, you should plan on spending time as a C&I Team and with other members of the department staff early in the process to discuss the scope and goals of your initiative as well as the meaning of the terms you will use.

Functions of Team Members

The project you are going to undertake by following the Handbook is going to require staff time and, quite possibly, departmental resources. To ensure that you have the authority and support to follow through on your efforts, management-leadership support of the C&I Team will be critical. To try to move ahead only to encounter unexpected resistance, either from peers or from management unfamiliar with your aims, is to invite disappointment or, worse, to reinforce the incorrect but common negative connotations of comprehensiveness and integration.

It is, therefore, imperative that at least one person on the C&I Team be the clear champion both internally and externally—more than one if you plan to embark on a multifaceted project that will place demands on others in your department. This individual must determine that the leadership is supportive, or they must persuade them of the merits of your plans. At the very outset—and then every step along the way—your project champion will have the responsibility of communicating with those who oversee all aspects of potential C&I Team activities about what you are aiming to accomplish and how.

Just how clearly you define the roles of every member of the C&I Team will have a tremendous bearing on your chances for success. Before you finalize your C&I Team and start analyzing project options, as a group you should try to define all of the functions that may come into play in your efforts. The list will be different for every health department, but the fundamentals include communications within the department, communications with outside partners, implementation support, evaluation, and follow up.

SECTION IV:
Matrix Assessment of Comprehensiveness (MAC)

Now that you have a C&I Team convened, you can look at your options for:

1) reaching toward a more comprehensive approach and

2) moving toward greater integration.

This may seem like a daunting task, but the purpose of the Handbook is to help you break it down into manageable steps.

The first step is to gain a more complete understanding of what level of comprehensiveness and integration activities is already in place. Included in the Handbook are a series of Matrix Assessment of Comprehensiveness (MAC) worksheets, pages 17–23, to help uncover both the current reality and the possibilities before you.

You will see on the following pages a series of blank worksheets related to Risk Factors, Populations, Partners, and Service Delivery. Also included are some sample "completed" worksheets to help you understand their function. These samples are meant to illuminate what your worksheets might look like, though they are by no means exhaustive.

These matrix worksheets are a simple, active way to get a snapshot of your department. Before beginning work on the MAC worksheets, think again as a group about who needs to be at the table to help complete them. The individuals who have signed on to be a part of the C&I Team may not have all the information.

How to Complete the MAC Worksheets

Complete each of the four MAC Worksheets according to the process described below. We recommend that the C&I Team (along with any ad hoc members) complete the worksheets together in a group, however if necessary they can be done by individual units and then merged by one selected individual or individuals.

Completing the Worksheets:

1) In the boxes in the top, horizontal row of each MAC Worksheet, write in all of the program units participating in this process. (For example, Cancer, Diabetes, Asthma). We suggest that you not attempt to include in your worksheets program units that are not included in the process as it may lead you to project ideas that do not have the buy-in necessary for implementation.

2) Next, in the far left, vertical column of each worksheet, list all Risk Factors, Populations, Partners, or Service Delivery mechanisms that pertain to your work and community in each program category included in the top row. For example, on your Risk Factor MAC Worksheet you might include Alcohol, Obesity, Tobacco, and Physical Inactivity.

3) Next, place an "X" in the boxes where each Risk Factor, Population, Partner, or Service Delivery intersects with categorical program activity column.

Examples for each MAC Worksheet are:

Risk Factors—If the Asthma unit focuses significant activity on preventing or reducing Obesity, put an "X" in the box found at the intersection of the Asthma column and Obesity row.

Population—If the Diabetes unit works closely with the African American community, put an "X" in the box found at the intersection of the Diabetes column and African American row.

Partner—If the Diabetes unit collaborates frequently with the American Cancer Society (ACS), put an "X" in the box found at the intersection of the Diabetes column and ACS row.

Service Delivery—If the Cardiovascular Health unit takes advantage of the mass media to get their message out, put an "X" at the intersection of the CV Health column and the Mass Media row.

Complete all four MAC Worksheets using the same methods. For this foundational exercise, we suggest you be as literal as possible. In other words, don't put "X" marks where they do not represent meaningful activity. At the outset, it is a good idea to agree as a group on what level of activities "qualifies" for an X. For example, you may decide that all "partners" listed must be current and significantly active within a program area to be included as an "X" in their column. Or you may agree that you only put an "X" next to a certain population if you have programs that explicitly focus on that specific population, rather than the "entire population."

Seeing Opportunities for Greater Comprehensiveness and Integration

The next step is to highlight where there are significant possibilities for greater comprehensiveness. Looking at the worksheets from the standpoint of existing resources, assess opportunities to enhance comprehensiveness by scanning the blank boxes and identifying where there could be activity where there is currently none. Place a tilde (~) in those boxes.

Despite enthusiasm for change, it is prudent to place limits on what actually qualifies for a tilde. For instance, it should not simply reflect where you can conduct activity, but where you need to conduct activity, based on data; creating new initiatives are not practical if they do not explicitly address an important chronic disease issue in your community.

As you will quickly see, the completed MAC Worksheets will illuminate where there are possibilities for integration—a horizontal series of X's and tildes suggests where important collaboration and coordination could happen.

Finally, review the completed MAC Worksheets. As ideas for projects begin to present themselves, place them in the blank worksheet that follows titled Opportunities for Comprehensiveness and/or Integration. We have provided a completed worksheet that suggests general categories for project ideas. Your goal is to develop ideas that are unique to your department.

You may see many areas where you could work together for better integration or comprehensiveness. It is helpful not get too caught up in the possibilities or you will be bogged down with difficulties before you even get started. The next section, Select Your Project, will help you identify which opportunities you are ready to pursue.

SAMPLE COMPREHENSIVENESS AND INTEGRATION MATRICES

COMPREHENSIVENESS AND INTEGRATION MATRIX

RISK FACTORS

SAMPLE RISK FACTOR MATRIX

RISK FACTOR	PROGRAM CATEGORY						
	Cancer	Diabetes	Asthma	CV Health	Arthritis		
Alcohol							
Obesity							
Tobacco							
Physical Activity							
Environmental Hazards							

COMPREHENSIVENESS AND INTEGRATION MATRIX

POPULATIONS

SAMPLE POPULATIONS MATRIX

POPULATION	PROGRAM CATEGORY						
	Cancer	Diabetes	Asthma	CV Health	Arthritis		
African Americans							
Women							
Youth							
Employers							
Entire Population							

COMPREHENSIVENESS AND INTEGRATION MATRIX

PARTNERS

SAMPLE PARTNER MATRIX

PARTNER	PROGRAM CATEGORY						
	Cancer	Diabetes	Asthma	CV Health	Arthritis		
Acme Hospital							
Blue Cross Blue Shield							
ACS							
Community Centers							
YMCA							

COMPREHENSIVENESS AND INTEGRATION MATRIX

SERVICE DELIVERY

SAMPLE SERVICE DELIVERY MATRIX

SERVICE	PROGRAM CATEGORY						
	Cancer	Diabetes	Asthma	CV Health	Arthritis		
Clinical/ Screening							
Mass Media							
Policy Development							
Health Education							
Outreach							

COMPREHENSIVE ASSESSMENT

For each empty box, ask the following questions:

- **Why is the box empty?**
- **Should we have activities in that box to be more comprehensive?**
- **What activities could we realistically add for that box that would move us toward comprehensiveness? Do we go about developing activities and, if so, who should be involved?**

EXAMPLE: The box where Diabetes and Alcohol intercept may be empty because the expertise and experience of the diabetes staff person is in obesity and physical activity. These areas have taken all of his/her time and not allowed him/her to add other intervention areas, though we know that alcohol is a risk factor for diabetes. To help address this gap, alcohol education materials developed for the Cancer program could be modified to target diabetes prevention, as well.

COMPREHENSIVENESS AND INTEGRATION MATRIX

RISK FACTORS

SAMPLE RISK FACTOR MATRIX

RISK FACTOR \ PROGRAM CATEGORY	Cancer	Diabetes	Asthma	CV Health	Arthritis		
Alcohol	X			X			
Obesity	X	X		X	X		
Tobacco	X			X			
Physical Activity	X	X		X	X		
Environmental Hazards	X		X				

ASSESSING INTEGRATION OPPORTUNITIES

Identify those rows that have more than one box marked and ask the following questions for those programs with activities:

- **Is there full awareness of activities across the row?**
- **Is there activity coordination or collaboration between programs?**
- **What opportunities exist for us to work together more effectively on common activities?**

EXAMPLE: Cancer, Diabetes, CVH, and Arthritis all address obesity, but are not fully aware of each others' activities. Only Diabetes and CVH worked together to develop media materials targeted at children. All programs also address physical activity and include seniors as a target population; they could work together to develop additional unified education messages around obesity and promoting physical activity among older adults.

EXAMPLES OF OPPORTUNITIES FOR COMPREHENSIVENESS AND/OR INTEGRATION

FUNCTIONS	STRATEGIES
Administration/ Management	• Identify resources to cover gaps in comprehensive effort. • Develop internal communication mechanisms to keep all chronic disease staff up-to-date on all chronic disease programs. • Fund staff with cross-cutting expertise (e.g., epidemiology) from multiple programs. **EXAMPLE:** Contra Costa Public Health Division looks specifically for funding that supports an integrative risk-factor approach in its work and negotiates with funders to maintain this approach so that even categorical funding streams can be used in a more integrated fashion.
Collecting and Managing Data	• Make sure that each program has access to every relevant data set. • Make sure that programs look across data sets for relevant data. • Issue chronic disease reports and briefs. • Link data sets to allow common risk factors to be analyzed with multiple specific outcomes. **EXAMPLE:** Data linkage efforts are a key focus of staff at the West Virginia Bureau for Public Health. Diabetes, asthma, cardiovascular and obesity programs in particular are leading the way in linking data sources to provide a broader picture of the state's chronic disease burden. Staff promote coordination between various contractors in data collection and communication between different data sets that overlap from different organizations.
Managing Partnerships and Coalitions	• Make sure that partnerships and coalitions have broad representation from areas affected by chronic diseases. • Seek out non-traditional partners that have a stake in common issues across chronic disease areas. • Identify partners working with multiple chronic disease units and coordinate contacts and common activities. **EXAMPLE:** North Carolina Division of Public Health has been instrumental in a number of statewide task forces concerning chronic disease prevention, which engage a wide range of partners throughout the state, giving them a voice in statewide planning efforts.
Planning	• Conduct a comprehensive planning effort or plan for risk factors not addressed in categorical plans. • Identify common elements of categorical plans and develop strategies for coordinated implementation. • Convene single risk factor planning efforts that all categorical plans will incorporate. • Maintain consistency and common language across categorical plans. **EXAMPLE:** The Texas Department of Health's Nutrition, Physical Activity, and Obesity Work Group is a prime example of a cross-cutting planning group brings together staff members working on disease-specific programs to focus on a single cross-cutting risk factor, in this case, obesity.

EXAMPLES OF OPPORTUNITIES FOR COMPREHENSIVENESS AND/OR INTEGRATION

FUNCTIONS	STRATEGIES
Involving Communities	• Make sure that targeted communities are represented in all aspects of planning, implementation, and evaluation across chronic disease interventions. • Involve community members as partners to foster ownership of the interventions. • Work with community partners and contacts jointly across programs. • Train outreach staff to be able to make cross referrals to other programs. **EXAMPLE:** Alameda County Public Health Department has built a strong history of community involvement across chronic disease prevention issues. Program development begins with identifying community needs. Community input is continuously sought through monthly meetings of a formal advisory group and ad hoc "town hall" meetings focusing on specific health issues.
Interventions: Communication	• Develop messages to reflect overall chronic disease priorities and reach all target audiences. • Develop messages that address cross-cutting chronic disease priorities. **EXAMPLE:** The Hawaii State Department of Health as established a priority of assuring consistency and coordination in all information on weight control and physical activity. As such they are conducting inventories of public education information currently in use, reviewing all materials for consistency and cultural appropriateness, and determining a comprehensive plan of delivery mechanisms and audiences for all information and materials.
Interventions: Policy	• Make sure all program interventions include social and environmental change strategies. • Develop and advocate for policies that impact multiple chronic disease conditions and risk factors. **EXAMPLE:** Boston Public Health Commission's public policy office is concerned not only with policy at the city level, but also at the state and even federal levels. Current policy issues at the legislature include a school physical activity and nutrition bill that regulates the use of vending machines in schools as well as a bill mandating time off for cancer screening for all state and municipal employees.
Evaluation	• Cover all priority risk factors, diseases, outcomes, and processes covered by funding, mandates, and planning. • Track multiple program interventions to common outcomes. **Example:** West Virginia Bureau for Public Health is tracking intervention activities provided at the local level for specific programs with an eye toward tracking progress toward meeting Healthy People 2010 objectives.

COMPREHENSIVENESS AND INTEGRATION MATRIX

RISK FACTORS

RISK FACTOR	PROGRAM CATEGORY						

COMPREHENSIVENESS AND INTEGRATION MATRIX

POPULATIONS

POPULATION	PROGRAM CATEGORY						

COMPREHENSIVENESS AND INTEGRATION MATRIX

P A R T N E R S

PARTNER	PROGRAM CATEGORY						

COMPREHENSIVENESS AND INTEGRATION MATRIX

SERVICE DELIVERY

SERVICE	PROGRAM CATEGORY						

OPPORTUNITIES FOR COMPREHENSIVENESS AND/OR INTEGRATION

FUNCTIONS	STRATEGIES
Administration/ Management	
Collecting and Managing Data	
Managing Partnerships and Coalitions	
Planning	
Involving Communities	
Interventions: Communication	
Interventions: Policy	
Evaluation	

SECTION V:
Selecting Your Project

Now that you have all of the information unearthed by the matrices, you are ready to select a project. As a team, make a list of all the possibilities for improving comprehensiveness and integration that address the gaps and issues that you identified in the MAC worksheets. You can draw from your worksheet on page 25 to help spark ideas and put possibilities into a framework.

It will be best to start by building upon existing activities represented in the matrices rather than by developing entirely new initiatives. As described in the Introduction, it is helpful to keep in mind that this is not a strategic planning process for redesigning your future, but instead a project-based pilot approach to pave the way for long-term impact.

As you generate ideas, be mindful of how this potential work fits into the bigger picture of the entire chronic disease prevention program, other heath agencies, and the work of outside partners. The goal is to create more impact, not simply more activity.

Look at what each department is doing with specific populations, around specific risk factors, with the same partners, with delivery of services. For instance, as you generate ideas related to partnerships, think about the many facets of partnership. Are there areas where you are doubling effort when you could be sharing the work? Are you missing an opportunity to bring a partner into a broader role? Are you overextending your partners? Are you sending them mixed messages from various areas of the division, rather than a unified message?

Your list of potential projects might look something like this:

- **Cancer and Diabetes programs produce a brochure together with a focus on the African American community;**
- **Data systems between programs may be linked; and**
- **Creating a consistent message around physical activity throughout all programs.**

Remember, the goal in comprehensiveness and integration is to maximize the impact of your work. This can mean saving resources where they are being expended redundantly or enhancing the work you're already doing by doubling its impact. Do the projects on your list accomplish this?

Criteria For Selecting Your Projects

Now that you have a list of potential projects, it is time to narrow your list to the best choice to get you started. Below is a suggested set of criteria that can help you determine your best option for success. It is a good idea to keep the entire list and use it for later planning as you complete your initial projects.

First, look at your list with an eye toward your department's primary goals. What are the greatest health disparities facing your community? How do the projects on your list relate to Healthy People 2010 or other goals you're striving to reach? Discard any project ideas that don't directly relate to your core set of goals and/or needs.

Next, look at each potential project and ask yourselves:

- **Does this project reflect clear departmental priorities?**
- **Is this project aligned with the priorities of your chief community partners?**
- **Is the project within the scope of the C&I Team at the table? Is there someone missing whose lack of participation could weaken the whole project?**
- **Does the project offer manageable comprehensiveness or integration opportunities?**
- **Are your leadership/partners/colleagues likely to rally around this project?**
- **Can this project have quick (e.g., six months) results and a high likelihood of success?**
- **Do you have the necessary commitment of human resources to implement the project?**
- **Will this project have a truly meaningful impact? For example, will it change the public health model in your department, save considerable resources, and/or maximize the efforts of partners?**

Your C&I Team may come up with other valid criteria, based on the current climate of your department.

Vetting the List

After applying the above criteria, your list of potential projects may shrink considerably. Ideally, it will be easy at this point to identify the three or four opportunities that best fit most or all of the criteria that you have defined. Now is the time to really test the viability of these ideas. This means not only brainstorming about the details of the projects as a group to see if they are truly workable, but starting to communicate about them with your colleagues to get initial reactions. It is critical to assess, at the outset, that your project won't be interrupted or undermined by outside forces. Ask yourselves:

- **Do you have the resources to implement each project?**
- **Has the leadership been fully informed of these ideas and have they committed their support to each potential project?**
- **Do you need formal approvals in other quarters?**
- **Are the staff who will be directly affected aware of the project and its implications for them? Are they supportive?**

It Won't Be Easy: List the Specific Barriers that You Expect to Encounter

Even with the smallest changes, resistance—or just inertia—can interfere with success. Before finalizing the choice of a project, it is important to assess the barriers you expect to encounter on the way to success. The following list is a starting point for identifying common barriers.

Ask yourself:

- **Are there costs to implementing the project? Can the individuals at the table find resources or partners willing to cover those costs?**
- **Will you have to share contacts that you previously kept to your own area?**
- **Will others in your department be unwilling to share information or help implement some of the measures, however small?**
- **Will the time and energy you need to invest in the project pull you away from your other work?**

Identifying barriers does not necessarily mean an idea must be abandoned. What is more important is identifying how you can address these barriers. If you identify many barriers for a project, but few solutions, it is a sign you may want to pick another project, or do more of the up-front legwork communicating internally about what you are about to attempt.

Getting Started

Now that you have identified your project(s), you are ready to identify your project team(s). It may be the same group of individuals who are on the original C&I Team, or some members may be added or replaced. The questions to ask are:

- **Who is committed to implementing this project?**
- **Who has the capacity to do so?**
- **Who will assume the key roles of project leadership, communications, etc.?**

With a team assembled, it is time to develop an action plan for your project. This should include a timeline, a list of deliverables, specific outcomes, and measurements that will let you know whether or not you have been successful. While this Handbook does not go into the details of project planning, it is important to set aside the time to discuss these planning issues and gain consensus among the group. Doing this project planning together is, most likely, the C&I Team's first foray into true integration.

One of the most important elements of the whole project will be to have a plan to communicate within your organization about the project and its aims. It is equally important to keep colleagues informed up and down the chain of command as well as sharing information with other departments laterally. Remember to communicate with outside partners, too.

Once your project is up and running, it is important to gather the C&I Team at regular intervals to evaluate progress, examine activities to date, and ensure that you are on track to deliver the outcomes the group has anticipated. Many find it useful to convene monthly for this purpose. A Troubleshooting guide is included as Appendix A; it may offer assistance if you find that you are encountering difficulties in implementing the project.

A Six-Month Review

At the six-month mark, you may want to consider holding a special C&I Team meeting to review the status of your project. Plan to present the outcomes of your work as well as the findings. Was the project successfully implemented? Was the impact as meaningful as expected? Were there secondary benefits that you did not anticipate? Now is the time to share progress, examine barriers, and learn from mistakes. This meeting can also serve as the starting point for selecting future project(s) from your original list of ideas, or to move your original project to a broader sphere of comprehensiveness and integration.

If it turns out that you are not seeing progress at this point, it is time to assess the impediments. Was the project truly a priority? Did something happen to change the environment in the department so that it could not be completed as hoped? Did outside pressures interfere with the project? Was there a lack of incentive for the people involved? The answers to these questions will help you determine your next steps.

CONCLUSION

The successful completion of a project deserves great celebration by the C&I Team. To help achieve the greatest impact, it will be valuable to share your results with others in your department.

But this is not the end of the process. A commitment to comprehensiveness and integration means ongoing effort to study how we work and make changes for the better; in that way, one successful effort can lead to the next. Through the implementation of a series of discrete comprehensiveness and/or integration projects—perhaps with a growing number of individuals and units involved—an evolution in the internal culture can occur while specific new outcomes are met.

The environment is ripe for a blossoming of greater comprehensiveness and integration measures in health departments at both the state and local levels. It is no longer easy to justify the rigid separation of the work of all categorical units. While the realities of categorical funding, and the missions of critical outside partners, can create challenges on the path to more coordination and collaboration, they are not insurmountable. Indeed, leadership commitment is crucial to effect sweeping change. The more quickly and more enthusiastically that situation is realized the better, but incremental progress as initiated in this Handbook can both develop leadership and advance the effectiveness of chronic disease prevention.

APPENDIX A:
Troubleshooting

CONVENING THE TEAM	
PROBLEM	**SOLUTION**
Staff don't understand the meanings of Comprehensive or Integration.	It is critical that all the staff involved and potentially impacted by the C&I process have a common understanding of what "comprehensive" and "integration" mean for your department. Have a discussion about what everyone thinks the meanings are and are not. Revisit the discussion of the meanings in Section II of this Handbook and use those definitions as a starting point for creating working definitions for your C&I Team.
Staff are suspicious or fearful of Integration (e.g., losing autonomy, sharing limited resources, and sharing recognition).	You can define integration as is appropriate for your department at any particular point in time. It may mean enhancing communications among prevention units, or it may mean experimenting with merging some resources. The fear may come from imagining a scenario where all categorical units are eliminated, which is not the only or primary meaning of integration.
Departmental leadership is lacking.	It will be helpful to take another look at what the departmental priorities and challenges are at the moment and be sure that the work you are embarking on doesn't conflict with either. Then review the communications you have had with the leadership and be sure you have clarified all of the potential reasons and benefits for undertaking a project.
Staff feel they lack the time to work on this type of unmandated project.	This may be a sign that you do not have the right members on your C&I Team. This effort will, indeed, take some time but it should actually create efficiencies in the long run. Make sure all team members truly understand and believe in the purpose of conducting a pilot comprehensiveness and/or integration project. If they are still balking at the time demands, it may be time to rethink the team. You may need to have a conversation with supervisors to discuss the importance of this effort and gain assurances for supporting staff participation.

IDENTIFYING AND IMPLEMENTING THE INITIATIVE	
PROBLEM	**SOLUTION**
The scope of project keeps growing.	This may be a sign that the team is either overly ambitious or fearful of really getting started on a project that will result in changes that will affect them. Everyone should be reminded that this isn't about changing the whole department. It's about conducting a pilot project to illuminate how certain steps, sometimes very easy steps, can transform the work in a very positive and specific way.
There is a lack of communication among C&I Team members and partners.	Review the C&I Team assignments. Is there a clearly defined role for one or more people to be in charge of communications? Perhaps it's too much for one person and needs to be divided among two or more. And perhaps the skill set of those individuals needs to be defined so that you're not asking communications of someone for whom it does not come naturally.
Categorical funding and grant requirements are real barriers to integration.	Categorical funding may present challenges to your efforts. The key is assessing your challenges to help you identify where you do and do not have control and thus, where you can make changes that will result in working better within the scope of our chronic disease efforts.
We have had some unanticipated obligations or priorities emerge in the middle of this process that threaten to put it on hold.	Depending on how urgent, important, and related to your efforts those priorities are you may have to put it on hold. You don't want to start this process, only to have it scuttled or done half-way because the other priorities have siphoned off too many resources. At the same, time you may need to assess with leadership how much of a priority the C&I process is. If the other priorities are related, can your C&I process be flexible enough to incorporate the needs of the emerging issues while still moving you in the direction of comprehensiveness and integration?

IDENTIFYING AND IMPLEMENTING THE INITIATIVE (CONT.)	
PROBLEM	**SOLUTION**
One "key" unit or individual refuses to participate.	At the point where you are selecting your first project, it is important to keep in mind who is already on the C&I Team and how that selection was conducted. If you tried to draw more units into the process and were met with skepticism, it is most likely going to be more productive to look at projects that only require the participation and commitment of those already involved in the process. The intention is that as the first project is completed successfully and results shared throughout the department, much of that skepticism will diminish.
We don't know what types of communication are critical to assist with implementation.	From the time you decide to start down this path, communication can make or break your efforts to be more comprehensive and integrated. While the "types" of communication are important, it is critical to identify the targets of communication. Very early on, your C&I Team should have a conversation about who needs to be informed of this process, ranging from department staff to external partners to policy makers. You should develop a plan for how you will keep those individuals and organizations updated.

GOING FORWARD	
PROBLEM	**SOLUTION**
How do we maintain the effort?	As described in the Introduction to this Handbook, the goal of taking on more comprehensiveness or integration projects is to start to create a culture within the department that looks to these two strategies for enhancing effectiveness. If your first project is a success it offers a great opportunity to pull more units into the process of selecting one or more new projects to undertake next. Communicating the results of your efforts and the history of the process will be the keys to increasing interest and buy-in.
There is a lack of commitment to long-term changes with our categorical approaches.	As described above, this Handbook is not aimed at prescribing an overhaul of a department. Rather, it is aimed at illuminating the possibilities of increasing comprehensiveness and integration at the program level. With that approach, the culture of the department may begin to change. While this may ultimately lead to structural changes within your department, that is not necessarily the goal nor the ideal.

APPENDIX B:
Resources

Materials and Web Sites

Assessment of State Capacity for Comprehensive Nutrition and Physical Activity Programs
http://www.astdhpphe.org/DNPAreportonstatecapacityonlineversion.pdf

Chronic Disease Prevention Databases
http://www.cdc.gov/cdp

CDC Comprehensive Cancer Control Resource Materials
http://www.cdc.gov/cancer/ncccp/resourcematerials.htm

Contra Costa Health Services, Spectrum of Prevention
http://www.cchealth.org/prevention/spectrum.html

The Essential Public Health Services
http://www.phppo.cdc.gov/nphpsp/10EssentialPHServices.asp

From Silos to Systems: Using Performance Management to Improve the Public's Health
http://www.turningpointprogram.org/Pages/Silos_to_Sytems_FINAL.pdf

Healthy People 2010
http://www.healthypeople.gov

Mobilizing Action Through Planning and Partnerships (MAPP)
http://mapp.naccho.org/MAPP_Home.asp

Partnership Self-Assessment Tool 2.0
http://www.partnershiptool.net

Planned Approach to Community Health
http://www.cdc.gov/nccdphp/patch/index.htm

State Health Promotion Capacity
http://www.astdhpphe.org/StateHealthPromotionCapacityReport.doc

Steps to a Healthier US
http://www.healthierus.gov/steps

Organizations

Association of State and Territorial Health Officials
http://www.astho.org

Center for the Advancement of Collaborative Strategies in Health
http://www.cacsh.org

Centers for Disease Control and Prevention
www.cdc.gov

National Center for Chronic Disease Prevention and Health Promotion
http://www.cdc.gov/nccdphp/index.htm

National Comprehensive Cancer Control Program
http://www.cdc.gov/cancer/ncccp/index.htm

National Public Health Performance Standards Program
http://www.phppo.cdc.gov/nphpsp/index.asp

Coordinated School Health Programs
http://cdc.gov/healthyyouth/cshp

Chronic Disease Directors
http://www.chronicdisease.org

Directors of Health Promotion and Education
http://www.astdhpphe.org

National Association of County and City Health Officials
http://www.naccho.org

National Business Group on Health
http://www.wbgh.com

National Council of State Legislatures
http://www.ncsl.org

National Governors Association
http://www.nga.org

Partnership for Prevention
www.prevent.org

Prevention Institute
http://www.preventioninstitute.org/index.html

Turning Point
http://www.turningpointprogram.org

Select Publications

Chronic Disease Epidemiology and Control, 1998. Brownson et. al, editors. Published by APHA.

Evidence-Based Public Health, 2003. Brownson et. al. Published by Oxford University Press.

The Future of the Public's Health, 2003. Committee on Assuring the Health of the Public in the 21st Century, Board on Health Promotion and Disease Prevention. Published by National Academies Press.

Promising Practices in Chronic Disease Prevention and Control: A Public Health Framework for Action, 2003. Dalmat and Wheeler, editors. Published by CDC.

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Workbook Registration Form

Hello! This form is accompanying the *Chronic Disease Action Planning Workbook Version 1*. This resource is a work-in-progress. In order to ensure that you receive updated versions, and to inform future versions through evaluation, please complete this form and drop it in the mail at your earliest convenience. Thank you!

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